

Qualaquin (quinine sulfate)
Prior Authorization Request Form



5622

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	<ul style="list-style-type: none">The provider may call: 1-866-684-4488 or the completed form may be faxed to: 1-866-684-4477
	<ul style="list-style-type: none">The patient may attach the completed form to the prescription and mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954 or email the form only to: TpharmPA@express-scripts.com

Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php.

Step 1 Please complete patient and physician information (please print):

Patient Name:	_____	Physician Name:	_____
Address:	_____	Address:	_____
	_____		_____
Sponsor ID #	_____	Phone #:	_____
Date of Birth	_____	Secure Fax #:	_____

Step 2 Please complete the clinical assessment:

Is Qualaquin being used to treat malaria?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Please sign and date	Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date.

_____	_____
Prescriber Signature	Date

Implementation: 6 October 2010